FH [redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION

MGE/148632

PRELIMINARY RECITALS

Pursuant to a petition filed April 11, 2013, under Wis. Stat. §49.45(5), and Wis. Admin. Code §HA 3.03(1), to review a decision by the Milwaukee Enrollment Services in regard to Medical Assistance (MA), a hearing was held on May 23, 2013, at Milwaukee, Wisconsin.

The issue for determination is whether the agency correctly processed petitioner's MA applications when he has no minor child living in his home, he is not elderly, blind or disabled as determined by the Disability Determination Bureau (DDB), and does not meet the requirements for Presumptive Disability.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:
Petitioner:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street
Madison, Wisconsin 53703
By: Lee Yang
Milwaukee Enrollment Services
1220 W Vliet St
Milwaukee, WI 53205

ADMINISTRATIVE LAW JUDGE:
Kelly Cochrane
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Milwaukee County.

2. On March 8, 2013 petitioner applied for Presumptive Disability – MA and Family Planning Services MA. See Exhibits 1 and 2.

3. On March 8, 2013 the agency also forwarded petitioner's application for Disability-MA to the Disability Determination Bureau (DDB). See Exhibits 3 and 4.

4. On March 12, 2013 the agency processed the Presumptive Disability – MA application and in error, found petitioner eligible for Presumptive Disability – MA.

5. At some point after that determination of eligibility, the agency discovered its error in finding petitioner eligible for Presumptive Disability – MA. On March 25, 2013 the agency sent a written notice to petitioner stating that effective April 1, 2013 his MA would end because there was no qualifying child under 19 in the household, petitioner is not age 65, legally blind, nor has he been determined disabled pursuant to federal Social Security disability regulations. Exhibit 5.

6. Petitioner does not have any of the impairments as attested to by a medical professional to qualify for Presumptive Disability – MA.

DISCUSSION

Medicaid (also called MA or Medical Assistance) is a federal-state medical assistance program for certain low-income individuals and is operated by state health or welfare agencies, under federal rules. MA benefits are extended to persons based upon categorical needy and medically needy eligibility. See Wis. Stat. §§49.46- 49.47. To be eligible as "categorically needy" an person must: (1) meet old AFDC eligibility requirements (be a caretaker of minor, deprived children); (2) receive or be eligible to receive federal Supplemental Security Income (SSI)(after being found disabled by the Social Security Administration); or (3) be verified as pregnant and meet specific income and asset limits. Wis. Stat. §49.46(1)(a).

Those not categorically eligible based upon the above factors may be eligible for MA based upon a "medically needy" determination. To be found "medically needy" a person must be one of the following: (1) 65 years of age or older; (2) under 18 years of age; (3) blind or totally and permanently disabled (as determined under Social Security guidelines); or (4) a woman who is verified as pregnant. In addition, a person must have income and assets below a certain level. See Wis. Stat. §49.47.

In this particular case, petitioner acknowledged that he does not meet any of the above eligibility criteria. However, further complicating this case for petitioner was the fact that the agency erroneously certified him as presumptively disabled. Although medical assistance covers disabled persons, the process for determining eligibility generally takes several months to over a year. In order to provide quicker coverage to those who will most likely meet the disability standards, MA rules have a process for determining presumptive disability. Those found presumptively disabled then receive medical assistance coverage while their disability application is pending. See *Medical Eligibility Handbook,* §5.9.1, available online at http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm.

As part of the presumptive disability process, petitioner's treating physician filled out the Medicaid Presumptive Disability form. Exhibit 1. That form has two sections. The first, titled Section I – Urgent Need for Medical Services, includes various boxes to indicate that the services are required immediately. The physician completed that part. The second, titled Section II – Impairments, includes the various impairments that will lead to a finding of presumptive disability. The physician selected the option that the petitioner met none of the listed impairments. However, the *Medical Eligibility Handbook,* §5.9.2 provides that:

> In determining that the *applicant* is presumptively disabled, the IM worker will need a "medical professional" to attest in writing that:
> 1. The individual's circumstances constitutes an urgent need (See 5.9.2.1 Definition of Urgent Need) for medical services, **and**
> 2. The individual has one of a certain set of impairments (See 5.9.2.2 Impairments).

Those guidelines reflect administrative rules found at Wis. Adm. Code §DHS 103.03(1)(e)3. Clearly the IM worker opened petitioner's case in error because it was only authorized to grant presumptive disability if both sections were completed as required.

The requirement for what impairments qualify states:

> When an urgent need for medical services has been identified, the IM worker can certify the member as presumptively disabled if the member has one of the following readily apparent impairments, as attested to in writing by a medical professional:
>
> 1. Amputation of a leg at the hip.
> 2. Allegation of total deafness.
> 3. Allegation of total blindness.
> 4. Allegation of bed confinement or immobility without a wheelchair, walker, or crutches due to a condition that's expected to last 12 months or longer.
> 5. Allegation of a stroke (cerebral vascular accident) more than three months in the past and continued marked difficulty in walking or using a hand or arm.
> 6. Allegation of cerebral palsy, muscular dystrophy or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of the hands or arms.
> 7. Allegation of Down's syndrome.
> 8. Allegation of severe mental deficiency made by another individual filing on behalf of a claimant who is at least seven years of age. For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school, because of mental deficiency or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities. Note: 'Mental deficiency' means mental retardation. This category pertains to individuals whose dependence upon others for meeting personal care needs (e.g., hygiene) and in doing other routine disability activities (e.g., fastening a seat belt) grossly exceeds age appropriate dependence as a result of mental retardation.
> 9. A physician or knowledgeable hospice official (hospice coordinator, staff nurse, social worker or medical records custodian) confirms an individual is receiving hospice services because of a terminal condition, including but not limited to terminal cancer.
> 10. Allegation of spinal cord injury producing inability to ambulate without the use of a walker or bilateral hand-held devices for more than two weeks, with confirmation of such status from an appropriate medical professional.
> 11. End stage renal dialysis confirmed by a medical professional.
> 12. The applicant's attending physician states the applicant will be unable to work or return to normal functioning for at least 12 months or the condition will result in death within the next 12 months.
> 13. The member has a positive diagnosis of HIV with other serious health conditions and will be unable to work or return to normal functioning for at least 12 months or the condition will result in death within the next 12 months.

Medical Eligibility Handbook, §5.9.2.2. In addition to the physician's attestation that he met none of the listed impairments, petitioner testified that he met none of these impairments at hearing, but that he was truly disabled and needed the MA.

In a case such as petitioner's, where an applicant has an urgent need, but does not have one of the listed impairments, the IM worker is required to request that the DDB make a presumptive disability

determination. See *Medical Eligibility Handbook,* §5.9.3. The IM worker must take the following actions once a medical professional has attested in writing, with the Medicaid Presumptive Disability form (F-10130), that there is an urgent need for medical services:

1. Document the urgent need by placing the Medicaid Presumptive Disability form (F-10130) in the case file.
2. Complete, with assistance from the applicant as necessary, the following two forms:

a. The Medicaid Disability Application form F-10112, (formerly DES 3071).
b. Release to Disability Determination Bureau form (F-14014).

3. See Process Help 12.0 for submissions of the forms, if necessary. This process is now automated. However, if the automated process isn't working, send via fax ([redacted]) each of the three forms listed above to DDB for both a presumptive and final disability determination.

DDB will make a presumptive disability finding on these cases and communicate their finding to the local IM Agency within three business days of receiving the request for presumptive disability and the F-10112 form (not including the day the fax was received).

Federal Regulations generally require the evaluation of certain disabilities after a three month period of recovery from the original injury or medical event (major head injuries, stokes [sic], heart attacks, etc.) It may not be possible to establish disability, either on a presumptive or final basis during that period. However, all applications should be submitted and a complete medical review will be made.

Medical Eligibility Handbook, §5.9.3. The agency provided proof that it submitted the Medicaid Disability Application form F-10112, and the Release to Disability Determination Bureau form (F-14014). What I cannot tell from the evidence is that the IM agency requested that the DDB make a Presumptive Disability determination. I must assume it did not now that over 3 months have passed. As such, I will remand the matter to the agency to resubmit the required documents described above in §5.9.3 and to request that the DDB make a Presumptive Disability determination.

CONCLUSIONS OF LAW

The agency did not correctly process petitioner's application for presumptive disability benefits because it failed to request the DDB make a presumptive disability determination.

THEREFORE, it is ORDERED

The matter is remanded to the agency to take the administrative steps necessary to request that the DDB make a presumptive disability determination for petitioner consistent with his March 8, 2013 application for same. These actions shall be taken within 10 days of the date of this decision.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative

Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee,
Wisconsin, this 18th day of June, 2013

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\sKelly Cochrane
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on June 18, 2013.

Milwaukee Enrollment Services
Division of Health Care Access and Accountability